Instructions for Completion of the RI Medical Marijuana Registration Forms and Fee Information

ALL PATIENTS:

1. All patients must be Rhode Island residents, complete and sign a "***Registration for Medical Marijuana Program – New Application***" ("Patient Form") and pay a fee. Patients may designate up to two (2) primary caregivers.

2. An "***Attending Physician Statement – New Application***" ("Physician Form") **MUST** be completed and signed by a physician, licensed to practice medicine in the State of Rhode Island, for each patient to participate in the RI Medical Marijuana Program.

MINOR PATIENTS (UNDER 18 YEARS OF AGE):

3. In addition to requirements listed above (items #1 and #2), minor patients **MUST** designate a custodial parent or legal guardian as one of their primary caregivers. **Additionally**, a "***Declaration of Person Responsible for a Minor to Participate***" ("Minor Form") must be completed, signed and submitted along with the Patient Form as described above.

CAREGIVERS:

4. Caregivers are not required to complete any forms. **Caregiver information is ALWAYS provided by the patient.** Each caregiver may be responsible for up to five (5) patients.

CHANGES OF INFORMATION:

5. Changes of information (once registered): After you (and your caregiver(s)) receive your registration identification cards, you can change information by completing, signing and submitting a "***Medical Marijuana Program – Patient Information Change Request***" ("Change Form").

WITHDRAWAL FROM PROGRAM:

6. You can withdraw from the Medical Marijuana Program by completing a "***Medical Marijuana Program – Patient Information Change Request***" (Change Form). Check box "D." "Withdrawal from Marijuana Program."

FEE INFORMATION:

All fees (check or money order only) must be made payable to the "General Treasurer, State of Rhode Island." Fees for participation in the Rhode Island Medical Marijuana Program are as follows:

NEW REGISTRATION:

There is a seventy-five dollar ($75.00) fee for the registration of the new patient. Provided, however, qualifying patients who submit satisfactory evidence to the Department of being a recipient of Medicaid, Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) shall submit a ten dollar ($10.00) fee. Please provide a **notarized copy** of your Medicaid, SSI or SSDI card with the application.

CHANGES TO INFORMATION:

Once you (and your caregiver(s)) are registered with the Rhode Island Department of Health, there is a ten dollar ($10.00) fee to change any information that would require the issuance of a new registration card. EACH NEW CARD ISSUED REQUIRES A TEN DOLLAR ($10.00) FEE. Old cards should be returned to the Department of Health.

DROP a Caregiver or ADD a NEW Caregiver:

DROP or ADD Caregiver – No Fee

LOST CARD

There is a ten dollar ($10.00) fee to replace your registration identification card.

WITHDRAWAL FROM PROGRAM:

There is **NO FEE** to withdraw from the Rhode Island Medical Marijuana Program.

PATIENT FORM

Office Use Only

Approved By:
Date of Approval:
Registration Number:

State of Rhode Island and Providence Plantations
Department of Health - Medical Marijuana Program
Office of Health Professionals Regulation, Room 104
3 Capitol Hill, Providence, RI 02908-5097

REGISTRATION FOR MEDICAL MARIJUANA PROGRAM - NEW APPLICATION

Instructions: *Please complete all sections of this form in order to comply with the registration requirements of the Rhode Island Medical Marijuana Act. Please mail the completed form to the address listed above.*
NOTE: You will be contacted to have your identification photograph taken upon application approval.

IMPORTANT: If you are a minor (under 18 years of age), you MUST designate your parent or legal guardian as your caregiver. Your parent or legal guardian must also complete an additional form, entitled "Declaration of Person Responsible for a Minor to Participate" (in the Rhode Medical Marijuana Program). Please attach the completed "Minor form" to this form and then submit both forms to the Department of Health.

A. PATIENT INFORMATION

Patient Name (First, M.I., Last)	Date of Birth:
Mailing Address:	Telephone Number: ( )
City, State, Zip Code:	Email Address:

B. ATTENDING PHYSICIAN INFORMATION

Physician Name (First, M.I., Last)	Telephone Number: ( )
Mailing Address:	
City, State, Zip Code:	

C. PRIMARY CAREGIVER #1

Caregiver Name (First, M.I., Last)	Date of Birth:
Mailing Address:	Telephone Number: ( )
City, State, Zip Code:	Email Address:

D. PRIMARY CAREGIVER #2

Caregiver Name (First, M.I., Last)	Date of Birth:
Mailing Address:	Telephone Number: ( )
City, State, Zip Code:	Email Address:

E. PATIENT'S ATTESTATION SIGNATURE AND DATE

I hereby certify that all of the information provided on this application is true and accurate to the best of my knowledge. I have attached a check or money order in the amount of seventy-five dollars **($75.00)** (NON-REFUNDABLE), made payable to the "**General Treasurer, State of Rhode Island.**" Provided, however, qualifying patients who submit satisfactory evidence to the Department of being a recipient of Medicaid, Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) shall submit a non-returnable, non-refundable application fee of ten dollars **($10.00)**. Please provide a **notarized copy** of your Medicaid, SSI or SSDI card with this application.

If I am incapable of completing or signing my name to this form, I have authorized my proxy to complete the form; attest to; and sign this statement. I also agree to notify the Department of Health, Office of Health Professionals Regulation, Medical Marijuana Program, in writing (use "Patient Information Change Request Form"), within ten (10) days of any changes to the information provided.

Patient's Signature:	Date of Signature:
Proxy's Signature (if applicable):	Date of Signature:

This form is to be completed by the Patient or Proxy and is for NEW applications only.

PHYSICIAN FORM

State of Rhode Island and Providence Plantations
Department of Health - Medical Marijuana Program
Office of Health Professionals Regulation, Room 104
3 Capitol Hill, Providence, RI 02908-5097

ATTENDING PHYSICIAN STATEMENT - NEW APPLICATION

Instructions: *Please complete section "A." and have your physician complete all other sections of this form in order to comply with the registration requirements of the Rhode Island Medical Marijuana Act.* *Please mail the completed form to the above address.*

NOTE: This does NOT constitute a prescription for marijuana

A. PATIENT INFORMATION

Patient Name (First, M.I., Last)	Date of Birth:
Mailing Address:	Telephone Number: ( )
City, State, Zip Code:	

B. PHYSICIAN INFORMATION

Physician Name (First, M.I., Last)	RI License Number:
Mailing Address:	Telephone Number: ( )
City, State, Zip Code:	Email Address:

C. PHYSICIAN'S STATEMENT

Debilitating Medical Condition - Check the appropriate box(es):

- ☐ 1. Cancer or the treatment of this condition
- ☐ 2. Glaucoma or the treatment of this condition
- ☐ 3. Positive status for Human Immunodeficiency Virus (HIV) or the treatment of this condition
- ☐ 4. Acquired immune deficiency syndrome (AIDS) or the treatment of this condition
- ☐ 5. Hepatitis C or the treatment of this condition
- ☐ 6. A chronic or debilitating disease or medical condition or its treatment that produces one or more of the following:
  - cachexia or wasting syndrome;
  - severe, debilitating, chronic pain;
  - severe nausea;
  - seizures, including but not limited to those characteristic of epilepsy;
  - severe and persistent muscle spasms, including but not limited to, those characteristic of multiple sclerosis or Crohn's disease;
  - agitation related to Alzheimer's Disease.

Comments:

D. PHYSICIAN'S ATTESTATION SIGNATURE AND DATE

I hereby certify that I am a physician duly licensed to practice medicine in the State of Rhode Island (Title 5, Chapter 37 of the RIGL). I have a physician-patient relationship with the qualifying patient and have completed a full assessment of the patient's medical history. The above-named patient has been diagnosed with a debilitating medical condition as listed above. Marijuana used medically may mitigate the symptoms or effects of this patient's condition. Further, it is my professional opinion that the potential benefits of the medical use of marijuana would likely outweigh the health risks for this patient.

Physician's Signature: Date of Signature:

This form is to be completed by the Attending Physician and is for NEW applications only.

MINOR FORM

State of Rhode Island and Providence Plantations
Department of Health - Medical Marijuana Program
Office of Health Professionals Regulation, Room 104
3 Capitol Hill, Providence, RI 02908-5097

DECLARATION OF PERSON RESPONSIBLE FOR A MINOR TO PARTICIPATE

Instructions: *Please complete all sections of this form in order to comply with the registration requirements of the Rhode Island Medical Marijuana Act. In addition to the patient application form,* ***this form is required if the patient is a minor*** *(under 18 years of age). Please attach this form to the Patient Application Form and mail the completed forms to the address listed above.*

A. PATIENT INFORMATION

Patient Name (First, M.I., Last)	Date of Birth:
Mailing Address:	Telephone Number: ( )
City, State, Zip Code:	

B. CUSTODIAL PARENT OR LEGAL GUARDIAN INFORMATION

Custodial Parent or Legal Guardian Name	Date of Birth:
Mailing Address:	Telephone Number: ( )
City, State, Zip Code:	Email Address:

C. DECLARATION

I _____ , do hereby declare:
Custodial Parent or Legal Guardian's Name

1. That I am the Custodial Parent or Legal Guardian with responsibility for health care decisions for:

_____ .
Patient's Name

2. The patient's attending physician has explained to the applicant and to me the possible risks and benefits of the medical use of marijuana;

3. I consent to the use of marijuana by the patient for medical purposes;

4. I agree to serve as the patient's designated primary caregiver; AND

5. I agree to control the acquisition of marijuana and the dosage and frequency of use by the patient.

D. SIGNATURES OF CUSTODIAL PARENT OR LEGAL GUARDIAN AND NOTARY PUBLIC

Custodial Parent or Legal Guardian's Signature: Date of Signature:

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by _____, who is personally known to me or has produced _____ as documentation.

Notary Seal

Name of Notary (Print, Type or Stamp): Signature of Notary: Notary No./Commission No.: Commision Expiration:

This form is to be completed by the Custodial Parent or Legal Guardian and is ***required*** *for a Minor Patient.*